

August 31, 2005

VIA FACSIMILE
Valley Total Health Systems
Attn: Nick Kempisty

VIA FACSIMILE
Continental Casualty Company / Burns Anderson Jury & Brenner
Attn: Deborah A. Womack

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-2227-01
TWCC #:
Injured Employee:
Requestor: Valley Total Health Systems
Respondent: Continental Casualty Company / Burns Anderson Jury & Brenner
MAXIMUS Case #: TW05-0177

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in psychiatry and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 45-year old female who sustained a work related injury on _____. The patient reported that while inspecting candles on an assembly line she twisted improperly and felt a sharp pain in her neck area. She suffered injury to her neck and left shoulder and she complained of numbness, heaviness and tenderness in the neck and left shoulder and aching pain to the hand with numbness. Diagnoses included cervical disc herniation, cervicgia and chronic neck pain. Treatment has included physical therapy, electrical stimulation, massage, exercise therapy, stretching, heat/ice, topical analgesics, injections, surgery, work conditioning, work hardening and oral medications.

Requested Services

Request chronic behavioral pain management times 10 sessions

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Denial letters – 7/5/05, 7/19/05
2. Request for Reconsideration – 7/5/05
3. Report of Medical Evaluation – 3/22/05
4. Review of Medical History, Physical Examination and Impairment Rating – 3/22/05
5. Valley Total Healthcare Systems Records – 6/14/05, 6/20/05, 7/5/05
6. Functional Capacity Evaluation – 1/19/04
7. Center for Pain Management Records – 5/16/03-10/20/03
8. South Texas Accident Center Records – 6/20/03-1/12/04
9. Southern Bone & Joint Center Records – 7/10/03,
10. McAllen Medical Center Records – 10/22/03, 1/15/04
11. Healthtrust, LLC Records – 11/18/03, 1/23/04
12. Outpatient Center for Interventional Pain Management Records – 5/10/05, 6/10/05
13. Synthesis Documentation – 2/17/04

Documents Submitted by Respondent:

1. Denial letters – 7/5/05, 7/19/05
2. Request for Reconsideration – 7/5/05

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

MAXIMUS CHDR physician consultant indicated the patient is a 45-year old female with a work related injury to her neck and shoulder with diagnoses including C4-5 and C6-7 disc herniations and radiculopathy. MAXIMUS CHDR physician consultant noted the patient has persistent neck and shoulder pain on the left side and she was diagnosed with myofascial pain syndrome that is now refractory to further physical therapy, injections, and typical conservative pain management efforts. MAXIMUS CHDR physician consultant explained that the member complains of persistent sleep problems, chronic fatigue secondary to reactive anxiety and depression. MAXIMUS CHDR physician consultant also indicated she was psychologically tested and the results confirmed her anxiety, depression and poor coping skills. MAXIMUS CHDR physician consultant noted she is not considered to be an appropriate candidate for one on one psychological treatment and has not been considered for selective serotonin reuptake inhibitors (SSRIs) or other antidepressants. MAXIMUS CHDR physician consultant also explained that the requested intensive effort at chronic pain management is a valid approach for treatment of this patient's pain. MAXIMUS CHDR physician consultant indicated that didactic and structured approach can teach this patient how to cope and function while managing her pain and allowing her to function more fully with her disability.

Therefore, the MAXIMUS physician consultant concluded that the requested preauthorization request for 10 sessions of chronic behavioral pain management are medically necessary for treatment of this patient's condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744

Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department

cc: Texas Workers Compensation Commission

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 31st day of August 2005.

Signature of IRO Employee: _____
External Appeals Department